ERIE COUNTY DEPARTMENT OF SOCIAL SERVICES
95 FRANKLIN STREET – BUFFALO, NEW YORK 14202

CHILD CARE – PAYMENT QUESTIONNAIRE

CLIENT NAME _____ **CASE #** _____

ADDRESS: _____, _____ NY _____

I M P O R T A N T

- **You and your child care provider must complete and sign this Questionnaire.**
- **A separate Questionnaire must be completed for each child care provider.**
- **A new Questionnaire must be completed and included with each Recertification.**
- **A new Questionnaire must be completed if you change child care providers.**
- **A new Questionnaire must be completed if your hours of employment change.**
- **A new Questionnaire must be completed if your household composition changes.**
- **A new Questionnaire must be completed if the cost of your child care changes.**

TO BE COMPLETED BY CENTER/PROVIDER

Provider: _____, DBA Name: _____

Providers SSN: _____-_____-_____ OR DBA TAX ID _____-_____

Site Address: _____, City _____, NY Zip _____

Mailing Address: _____, City _____, NY Zip _____

Contact Person: _____ Phone #: (_____)-_____-_____

License #: _____ License Period: _____/_____/_____ to _____/_____/_____

CCFS Permit #: _____ Expiration Date: _____/_____/_____

Vendor #: _____

Are you in receipt of Temporary Assistance? ☐ YES ☐ NO

If **YES**, enter your Case#: _____

Please indicate if your business can be categorized as being owned by <u>any</u> of the following:

☐ AA-Asian American ☐ Black ☐ Hispanic ☐ AI-Native American ☐ WO-Woman Owned ☐ Veteran Owned

Provider Signature _____ Date: ____/____/____

RETURN TO:

CASEWORKER/EXAMINER _____ **UNIT / WORKER #** _____/_____

PHONE # 858- _____

I. PARENT: COMPLETE PLACE OF EMPLOYMENT/TRAINING: _____

COMPLETE DAILY WORK/TRAINING SCHEDULE (e.g. 9am-5pm)

Mon	Tues	Wed	Thurs	Fri	Sat	Sun

II. PROVIDER: COMPLETE FOR EACH CHILD IN CARE

	CHILD 1	CHILD 2	CHILD 3	CHILD 4	CHILD 5
Child's Name					
Child's DOB					
Child's school schedule (e.g. 9:00 am - 3:00 pm)					
Date child started in care					
Hours in care per day					
Circle days in care per week	M T W Th F S Su	M T W Th F S Su	M T W Th F S Su	M T W Th F S Su	M T W Th F S Su
Hourly cost of day care					
Part Day cost of day care					
Daily cost of day care					
Weekly cost of day care					

PAYMENT TYPE (Agency Use Only)		III ENTER A (🗐) TO INDICATE THE CURRENT CHILD CARE ARRANGEMENT FOR EACH CHILD					
FULL Time	PART Time	CURRENT CHILD CARE ARRANGEMENT	CHILD 1	CHILD 2	CHILD 3	CHILD 4	CHILD 5
37	38	Day Care Center					
34	36	Group Family Day Care Provider					
32	33	Family Day Care Provider					
R8	R6	School Age Child Care Program					
R0	R1	Watched in Your Home by a Relative					
30	31	Watched in Your Home by a Non-Relative					
R2	R3	Watched in a Relative's Home					
R4	R5	Watched in a Non-Relative's Home					

NOTE: **Payments will be based on the actual number of hours employed, plus a reasonable travel time allowance.**

THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

_____ _____ _____ _____

CLIENT'S SIGNATURE **DATE** **PROVIDER'S SIGNATURE** **DATE**